
Borderline Personality Disorder and DSM-5: New Directions and Hopes for the Future

27

Merav H. Silverman and Robert F. Krueger

Despite advancements in research on and treatments for borderline personality disorder (BPD), which have relied on the current formulation of the diagnosis as presented in DSM-IV, growing evidence argues for reassessing how we understand the BPD diagnosis, in the context of a broader sea change in our understanding of personality disorder (PD) psychopathology. An increasing body of research, driven by a strong theoretical framework and fueled by empirical studies, provides evidence for remodeling the overall framework of PDs in an effort to make the diagnoses more valid, more descriptive, and more clinically relevant. In this chapter we discuss certain of the main challenges to DSM-IV PDs and the process of developing the PD sections in DSM-5. We particularly focus on the implications for research and treatment, with an eye toward the impact of changes for children and adolescents.

Over the past 30 years, there has been a proliferation of research on BPD. To date, research on BPD has relied on the model of the disorder presented in DSM-III and the modifications of the diagnosis found in subsequent revisions of the DSM (III-R, IV, and IV-TR). This research has shed light on the etiology, course, and prevalence of the disorder. In conjunction with an

improved understanding of the disorder, progress has been made in creating and disseminating treatments for BPD; in recent years, a number of treatments have been developed for BPD, which have been validated empirically and manualized, allowing for wider distribution and improved quality of care for borderline patients. While the majority of the contemporary research on BPD has been in adult samples, recent studies have verified the positive value of identifying and treating BPD at younger ages (Chanen et al., 2007). This finding, along with a general interest in early interventions for psychopathology, means that there now exists a growing literature about BPD and BPD symptoms in children and adolescents. Using the current diagnostic criteria set for BPD found in DSM-IV-TR (henceforth in this chapter, DSM-IV), a great deal of progress has been made, furthering our understanding of the disorder, garnering public attention for the disorder, and improving treatments for very impairing symptoms.

Still, despite the progress that has been made using the current model of personality pathology, there is a compelling case for using what we know about basic personality to shed light on PDs, thereby bridging the gap between these two, currently disparate, areas of research (Markon, Krueger, & Watson, 2005; Widiger, Livesley, & Clark, 2009). This, along with a growing literature on the underlying structure of PDs, which provides an evidence-based alternative to the current medical-categorical model of PDs, has coincided with the preparation of

M.H. Silverman (✉)
Department of Psychology, University of Minnesota,
Minneapolis, MN, USA
e-mail: silve369@umn.edu

DSM-5. This has brought the question of the future of PD diagnoses to the forefront of both researchers' and clinicians' minds.

As it stands in DSM-IV, in order to receive a diagnosis of BPD, a person must exhibit an enduring pattern of instability, manifested in interpersonal relationships, self-image, affect, and impulsivity. This pattern must be evidenced in early adulthood and must be present in many areas of functioning. DSM-IV identifies nine criteria indicative of BPD. In order to receive a diagnosis of the disorder, a person must show five or more of the following symptoms: efforts to avoid abandonment, unstable interpersonal relationships, unstable self-image or sense of self, impulsivity, suicidal and self-injurious behaviors, unstable affect, feelings of emptiness, difficulty with controlling anger, and transient, stress-related paranoid, delusional, or dissociative symptoms. The current diagnostic criteria are made up of a combination of specific behavioral symptoms, similar in feel to symptoms one would see in Axis I diagnostic criteria, and more enduring, trait-like criteria.

Though the current diagnosis captures many features of BPD, and has been a useful tool for better understanding and treating patients with the disorder, a growing body of research highlights the shortcomings in the current BPD diagnosis. Enough evidence had accumulated such that, with the revision of DSM-5 approaching, many in the field thought it was time to reconsider the structure of the disorder. Many researchers involved in the DSM revision process felt that the categorical diagnosis of BPD did not represent the most compelling articulation of the dysfunctions present in patients with BPD. They also identified the shortcomings of the DSM-IV diagnosis as a clinical tool, noting that it did not capture the ways that patients present in clinics and hospitals. The challenges to the BPD diagnosis, as with the other PD diagnoses, are not simply abstract or academic. Rather, they have a direct bearing on clinicians' ability to conceptualize cases and develop treatment plans for severely impaired patients.

With a sense that the limitations in the BPD diagnosis were hindering treatment of and research on the disorder (and with similar concerns existing for the other PDs, as well), the researchers and clinicians who were chosen to serve on the Personality and Personality Disorder (P & PD) Work Group for DSM-5 proposed alterations to the framework of the PD section of the DSM. The members of the work group were selected for their extensive research on PDs and their experience working with these patients. Throughout the process, BPD in particular captured the attention of many in the field, due to its prominent status as the most researched and treated of the PDs. Because of this, both researchers and clinicians cared a great deal about the future of the disorder.

Many of the criticisms of the current model of BPD are not specific to BPD but rather pertain to the entirety of the PD section of DSM-IV. These limitations have been discussed at length elsewhere (Clark, Livesley, & Morey, 1997; Krueger & Eaton, 2010; Krueger, Markon, Patrick, & Iacono, 2005; Westen and Shedler, 2000; Widiger & Trull, 2007) but will be covered here in brief. Four key limitations, in particular, have proven vexing in the current diagnostic system and serve as the primary intellectual impetus behind the argument for restructuring PD diagnoses in DSM-5. These include polythetic and dichotomous diagnoses, excessive comorbidity of psychiatric disorders, inadequate coverage of psychiatric dysfunction using our current diagnostic categories, and lack of diagnostic stability over time.

The first part of this chapter will explore these theoretical challenges to the current conception of BPD and some of the ways that these conceptual difficulties hinder further research, case conceptualization, and treatment. Next, we will outline the process by which the PD section for DSM-5 was developed, and will explain, in brief, the final PD sections in DSM-5. Subsequently, we will explore some of the future directions and anticipated changes moving forward, beyond the publication of DSM-5. Special attention will be paid to the ways that these changes may impact

research and treatment of BPD and BPD symptoms in children and adolescents. It is important to emphasize that the goal of these proposed changes is to provide a more precise method of describing and diagnosing BPD in order to improve the quality of research and to aid clinicians in their diagnosis and treatment of the disorder. Ultimately, the intention is that these changes will better serve those researching BPD and improve treatments for patients suffering from the disorder.

Challenges to DSM-IV Personality Disorders

Polythetic Dichotomous Diagnoses

In our current diagnostic system, PD diagnoses are conceptualized as polythetic dichotomies. The polythetic nature of the diagnoses indicates that many different combinations of symptoms can lead to the same diagnosis and that not all symptoms for a specific diagnosis need to be met in order for a person to meet for that diagnosis. Dichotomous means that diagnoses are established using a threshold of symptoms. If persons present with the number of requisite symptoms for a diagnosis, or higher than that number, they would meet for a disorder. Alternatively, if they present with a subthreshold number of symptoms, they would not receive a diagnosis. In this way, the diagnoses are considered as a yes/no distinction, with no room in the rubric for gradations of a disorder.

Before DSM-III-R, certain PDs, such as dependent PD, were diagnosed using monothetic criteria sets, meaning that all symptoms had to be present in order to receive that diagnosis. Other PDs were diagnosed using polythetic criteria sets (Oldham, 2005). Revisions for DSM-III-R included making all of the PD criteria sets polythetic, after determining that monothetic diagnostic systems were not reliable. Monothetic criteria sets were considered too restrictive to capture the heterogeneity in these disorders; therefore, the writers of DSM-III-R converted all of the PDs to polythetic criteria sets (Pfohl,

Coryell, Zimmerman, & Stangl, 1986; Widiger, Frances, Spitzer, & Williams, 1988). As compared to monothetic criteria sets, polythetic criteria sets allow for more flexibility in the diagnoses by allowing phenotypic variation in the symptom manifestations of the disorders (Cooper, Balsis, & Zimmerman, 2010).

Polythetic criteria sets mean that patients can present with only a portion of the criteria that define a disorder; as long as they have met the symptom threshold, they receive the given diagnosis. The specific number of symptoms that serves as the threshold varies from one PD to the next. For example, in order to receive a diagnosis of BPD a person must endorse five diagnostic criteria or more out of nine possible criteria; for obsessive–compulsive PD a person needs to meet four or more out of a possible eight criteria. Practically, a polythetic classification system of PDs means that it is possible for there to be very little symptomatic overlap among patients with the same diagnoses. For BPD, specifically, there are 256 different combinations of symptoms that all result in a person receiving a diagnosis of the disorder. Another way to think about this is that two patients presenting with a diagnosis of BPD may only share one symptom in common. For obsessive–compulsive PD, mentioned above, the reality is even starker, in that two patients may not share any disorder-specific symptoms but might nonetheless receive the same diagnosis. This extreme level of phenotypic variation creates challenges for research and treatment of PDs.

In addition to the problem of arguably too much symptom variation within the current system, polythetic criteria sets also introduce the challenge of developing diagnostic cutoffs. Whereas disorders diagnosed using monothetic criteria sets did not need a threshold, in a polythetic diagnostic system a specific point needs to be established where above a certain symptom count, a person meets for a diagnosis (Oldham, 2005). A person that meets for one symptom less than that diagnostic cutoff point, from a diagnostic standpoint, is considered to be free of personality pathology. From a clinical standpoint, it would be hard to imagine that this

person would be treated as if he or she suffered from no features of the disorder. Using categorical classification, though, there would be no way to classify subthreshold impairment.

Deciding where to set appropriate diagnostic cutoffs for PDs has proven quite challenging, as there is no clear boundary above which it is obvious that a person's behavior is pathological. Furthermore, it is unclear whether more symptoms (or even above threshold symptom counts as opposed to below threshold symptom counts) necessarily indicate a worse clinical presentation or course. For example, it is likely that there are certain combinations of four BPD symptoms, which would be subthreshold for a BPD diagnosis, yet might indicate a worse clinical course than a different combination of five BPD symptoms, which would receive a BPD diagnosis. This is largely due to the fact that all PD symptoms are not viewed as having equal clinical weight, though they are all treated equivalently in the current DSM. Thus, clinicians already will emphasize certain symptoms more heavily in their PD diagnoses than other symptoms (Cooper, Balsis, & Zimmerman, et al., 2010). Still, there is no room in the current diagnostic system to indicate differing severity depending on specific symptoms nor is there a way to indicate a subthreshold combination of symptoms that still warrants significant clinical attention.

Furthermore, the current diagnostic cutoffs are not based on empirical evidence, but instead have been chosen somewhat arbitrarily (Kamphuis & Noordhof, 2009). Often the argument given to justify the thresholds is that they are generally about half of the symptoms of a given disorder. Though establishing a demarcation between the presence and lack of a disorder is necessary and has utility, particularly for treatment and communication of patient information, the cutoff points in the current categorical system have little scientific basis. Using a model of psychopathology aside from the medical-categorical system, such as a hybrid or dimensional model, would change our reliance on specific diagnostic cutoffs (Hopwood & Zanarini, 2010; Morey & Zanarini, 2000; Skodol

et al., 2011). Within a more dimensional system it would be possible to indicate impairments, even if they were subthreshold, which would lessen the importance of chosen thresholds. Regardless of what kind of system is employed, it is important that cutoffs are meaningful.

An additional problem with the current diagnostic cutoffs is that no distinction is made based on patient severity. A patient who meets five criteria for BPD, and gets a diagnosis of BPD, is not described any differently than a patient who meets for all nine criteria, even though meeting for nine criteria in most cases implies a worse prognosis and a different course of treatment. The challenges of diagnostic cutoffs extend as far as to each individual symptom, many of which exist on dimensions but are rated as either present or absent. For example, symptoms such as identity confusion or entitlement most certainly exist on some sort of continuum as opposed to on a yes or no dichotomy, as they are currently assessed (Westen et al., 2003). Though it may always be necessary to identify boundaries in order to have a meaningful classification system, it is important that the choices for cutoffs, even at the level of symptom severity, are guided by theory and validated models.

The combined impact of polythetic dichotomous diagnoses means that in our diagnostic system for BPD, we include a variety of patients who share very little symptom overlap and we simultaneously exclude many patients from receiving diagnoses despite potentially severe clinical presentations. This creates problems for research and for treatment development. Though the decision to change all of the PD diagnoses from monothetic to polythetic criteria sets gave the diagnostic categories more flexibility, and has since been standard in PD diagnostics, the current classification system includes diagnoses, which are very broad, lacking specificity as a result of the heterogeneity of symptomatic manifestation. Simultaneously, it can also be argued that the diagnoses are too narrow, providing no way to identify certain patients with subthreshold levels of personality symptoms or to differentiate more severe BPD patients from milder presentations.

Psychiatric Comorbidity

One of the most challenging diagnostic issues across the board in DSM-IV is the high rate of comorbidity for psychiatric patients. Using DSM-IV diagnoses, there is widespread comorbidity between BPD and other Axis I and Axis II psychopathology. Like in all fields of medicine, diagnostic criteria sets are designed to help guide clinicians toward the correct diagnosis of each patient and to enable differentiation between one disorder and other similar disorders. In theory, this would enable a clinician to understand a specific case as it relates to a paradigmatic example of that diagnosis. The supposed overlap between a patient's clinical presentation and the DSM's delineation of a diagnostic criteria set should cue a clinician to a narrow set of treatment options.

Still, in DSM-IV, there are very few stipulations about meeting for multiple disorders simultaneously. Thus, as they are conceptualized in DSM-IV, psychiatric diagnoses co-occur routinely and to such an extent that it becomes challenging to argue that the diagnoses represent distinct clinical entities (Mineka, Watson, & Clark, 1998). The question of diagnostic comorbidity, and what it means for our understanding of psychopathology, and is particularly pertinent to PDs, as they have been evaluated on a separate axis in DSM-IV and therefore routinely co-occur with diagnosed Axis I disorders (Clark, 2005; Krueger, 2005; Krueger & Markon, 2006).

The high comorbidity rates seen in patients with BPD seem to indicate that this problem might be more ubiquitous in this diagnosis than in other diagnoses. The rates of psychiatric comorbidity frequently complicate case conceptualization and treatment of BPD (Zanarini et al., 1998a). One study of inpatients with BPD found that borderline patients had comorbid PDs at the following rates: 31 % for odd cluster disorders, 73 % for anxious cluster disorders, and 40 % for dramatic cluster disorders (Zanarini et al., 1998b). In a study of the rates of comorbidity between BPD and Axis I psychiatric diagnoses, 75 % of individuals with a lifetime BPD diagnosis

met criteria for a lifetime mood disorder and 73 % met criteria for a lifetime substance abuse disorder (Grant et al., 2008). In a study looking at the longitudinal course of anxiety disorders in borderline patients, 80 % of the borderline patients met for a simultaneous anxiety disorder at baseline (Silverman et al., 2012). Another recent study found that the rates of comorbid Axis I and Axis II disorders and BPD in adolescents were particularly high, compared to a clinical control group, particularly for mood, eating, dissociative and substance abuse disorders, and for cluster C personality disorders (Kaess et al., 2013).

This is not an exhaustive list of studies on BPD comorbidity but these selected studies should indicate the extent to which this problem exists within the BPD diagnosis. Further, the literature on this topic points to the degree to which it is a vexing problem for researchers, trying to conceptualize and differentiate these disorders. From a theoretical and philosophical standpoint, comorbidity begs questions about the nature of our diagnostic system and the individual integrity of each DSM diagnosis, if disorders so frequently co-occur. From a practical standpoint, the problem of comorbidity impacts the ability for researchers to study and develop treatments for disorders. In order to conduct research on a treatment for BPD, is it important for participants to meet for BPD alone? If the answer is no, then it would be hard to know whether positive improvements in the participant were due to changes in BPD or other comorbid disorders. If the answer is yes, then any participants in a treatment study would be aberrant from the typical BPD patient, who often presents with multiple disorders. Therefore, findings from this hypothetical treatment study would be hard to generalize. These questions are not simply theoretical; high rates of comorbidity serve to hinder effective research about the nature, course, and treatment for BPD.

From a clinical standpoint, the issue of comorbidity raises questions about which treatments to use. For many Axis I and Axis II disorders there are specific empirically validated therapies, which

have been shown to be effective for treating those disorders. A great deal of progress has been made in the arena of validated treatments for BPD. A number of treatments have been designed specifically to treat BPD, such as dialectical behavioral therapy (DBT), mentalization-based treatment (MBT), transference-focused psychotherapy, and schema-focused therapy, among others (Bateman & Fonagy, 2004; Clarkin, Yeomans, & Kernberg, 1999; Linehan, 1993; Young, Klosko, & Weishaar, 2003). Still, when patients suffer from multiple disorders, for example BPD and an eating disorder or BPD and an anxiety disorder, it is difficult for clinicians to know which disorder should be tackled first, or whether both disorders should be treated simultaneously. If a clinician treats a patient with multiple disorders, which given the high rates of comorbidity is not unusual, what would be the ideal treatment to use, for that patient, with that combination of disorders?

We are in a new age for treatments for psychiatric disorders, with a growing acknowledgement of the importance of using empirically validated treatment modalities. Yet the problem of comorbidity means that it is difficult for a clinician to know how to target multiple disorders simultaneously, even when there are validated treatments for the individual disorders. Recently, there have been efforts to modify existing treatments in order to target more than one disorder at a time, when those disorders are commonly comorbid with one another. For example, DBT has been modified to treat BPD comorbid with drug dependence (Linehan et al., 1999, 2002). Still, this method of treatment development is inefficient, as it is nearly impossible to tailor existing treatments to include all of the various possible combinations of comorbidities. The question of comorbidity in a medical-categorical classification system, then, ultimately impacts the type and quality of care that patients receive and creates challenges for the clinician looking for a proper course of action for treating a patient. Taken together, the research suggests that the problem of comorbidity in the BPD diagnosis is prevalent, pertinent for adolescents with BPD diagnoses, and impacts the quality of patient treatment and care.

Inadequate Coverage

Comorbidity is a problem in that diagnoses do not seem to reflect distinct entities. A seemingly opposite problem in the current diagnostic classification system is that of the ubiquity of the “not otherwise specified” (NOS) label. An NOS qualifier can be appended to any Axis I or Axis II diagnosis and is given when a clinician determines that a patient suffers from a certain class of psychiatric disorders but does not meet enough symptoms to receive a diagnosis within that category. Thus, an NOS diagnosis describes the overall framework of a person’s dysfunction but provides no incremental specificity about the nature of the impairments. Unlike comorbidity, which is the result of multiple distinct categorical diagnoses, the NOS diagnosis indicates that a certain amalgam of symptoms is impairing, but is impossible to further categorize beyond the family of disorders in which it falls (Widiger & Trull, 2007).

A diagnosis of personality disorder—NOS (PDNOS) is given when a patient meets general diagnostic criteria for a PD but not the full criteria for any single PD. The general diagnostic criteria for a PD indicate impairments in cognition, affect, interpersonal relationships, and impulsivity, without specifying details of impairment. Studies looking at the prevalence and usage of the PDNOS diagnosis found that the best estimate of relative prevalence of PDNOS, as compared to Axis II prevalence without PDNOS, was in the range of 21–49 % (Verheul & Widiger, 2004). In reality, it is the most frequently assigned PD diagnosis (Clark, Watson, & Reynolds, 1995). A common example of a PDNOS diagnosis is when a patient presents with features of multiple personality disorders but does not meet criteria for any single PD. Thus, the only descriptive information in the diagnosis is that a patient is suffering from multiple symptoms of maladaptive personality, which cause clinically significant distress or impairment. No information is given about the nature of the impairments or what the patient is experiencing. In a study of the PDNOS

diagnosis, patients receiving a diagnosis of PDNOS did not differ significantly from those that met for a single specific PD (Verheul, Bartak, & Widiger, 2007). Furthermore, in terms of quality of life and psychosocial functioning, subjects in the study with PDNOS had a higher degree of pathology, similar to that of subjects with a specific PD diagnosis, and not to Axis I patients or healthy individuals (Coccaro, Nayyer, & McCloskey, 2012). This research lends credence to the clinical severity of patients with a PDNOS diagnosis and the importance of properly treating these patients. It also supports the notion that DSM-IV is not providing adequate coverage for patients with pathological personality traits.

Despite the seriousness of the PDNOS diagnosis, this diagnosis conveys nothing about the specific maladaptive patterns and behaviors that characterize patients. This makes developing an effective treatment plan based on the diagnosis nearly impossible. In some ways, it is worth thinking about PDNOS as an example of a polythetic diagnosis writ large. Similar to the problems for research and treatment created by the fact that 256 different combinations of symptoms all fall under the category of a BPD diagnosis, there are potentially thousands of symptom combinations that all warrant the PDNOS diagnosis.

Needless to say, there is very little that binds PDNOS as a unitary diagnosis. As a clinician, knowing how to treat an amalgam of unspecified symptoms that are characterized by an enduring, stable, and pervasive pattern of a combination of maladaptive cognitions, affect, interpersonal functioning, and problems with impulse control, and which leads to clinically significant distress, is quite daunting. The lack of descriptive information about the disorder also hinders the ability to produce a conclusive body of research about PDNOS. Aforementioned studies have established the necessity of maintaining PDNOS as a diagnostic category and have shown that the disorder can be quite impairing. It is important, then, to have a way to identify these patients. Still, as it stands, it is challenging to conduct meaningful research on such a

nebulous disorder, with literally thousands of potential presentations. It is equally challenging to establish treatment standards for this patient population.

Lack of Diagnostic Stability

To date, PDs have been distinguished from Axis I psychopathology in that they are considered to be more stable, pervasive, and enduring than Axis I disorders (Gunderson & Pollack, 1985; Widiger & Shea, 1991). According to DSM-IV, one of the defining features of PDs is that they onset during adolescence and remain stable over time. Thus, the very nature of a PD diagnosis rests on its stability and the enduring nature of the dysfunctions present. Research has shown that the stability associated with PDs, and specifically with BPD, in reality is an elusive concept. In a longitudinal study on the course of BPD, Zanarini et al., (2012) found that after 16 years of prospective follow-up, 99 % of the patients that had originally met for BPD had experienced at least a 2-year remission of symptoms. For a disorder that by its very definition is expected to be stable over time, these results are surprising.

Furthermore, according to DSM-IV, BPD is supposed to begin before a person reaches adulthood and continue into adulthood. Studies on the temporal stability of adolescent BPD, though, have produced results that are inconsistent with this criterion. In a study of a small sample of hospitalized borderline adolescents, only two out of the 14 cases continued to receive a diagnosis of BPD after 3 years post-hospitalization (Meijer, Goedhart, & Treffers, 1998). In a similar study of patients with BPD in the community, researchers found that less than one third of the adolescents who met for BPD at baseline continued to meet criteria for the disorder after 2 years of follow-up (Bernstein et al., 1993).

Examining these findings, Bornovalova et al., (2009) point out that many of the studies looking at the temporal course of BPD in adolescence use dichotomous diagnoses of BPD (as it is defined in DSM). As explained above, a dichotomous diagnostic system means that an affirmative

diagnosis of BPD can hinge on a single diagnostic criterion, making it relatively easy to transition from meeting to not meeting the diagnosis. This is regardless of whether a person continues to exhibit a number of symptoms and traits associated with the disorder. Chanen et al. (2004) conducted a study comparing the BPD diagnosis in adolescents measured categorically to a dimensional measurement of BPD. They found the categorical stability to be low over time in adolescents, but that stability of the diagnosis was considerably higher when measured dimensionally. More generally, a paper from the Children in the Community study on the developmental course of PDs found that nearly all PD symptoms decline linearly between the ages of 9 and 27 (Johnson et al., 2000). Thus, despite the fact that stability over time has been considered a defining feature of PDs generally, and of BPD specifically, empirical studies evaluating the stability of the diagnosis have shown that it generally remits over time, in both adults and children. This problem is compounded by our current categorical diagnostic system. It is probable, as previous research suggests, that a dimensional model of diagnosing PDs would be more effective at capturing personality pathology present in children and adolescents, by better accounting for shifts in personality that are age appropriate.

DSM-5 and Hopes for Beyond

Over the last 20 years, both the theoretical and practical shortcomings of the DSM-IV diagnostic criteria for PDs, as described above, were significant enough to inspire many researchers in the field to consider DSM-5 as an opportunity for constructive evolution. The shortcomings enumerated above as well as data supporting a dimensional model of personality pathology in large-scale samples indicated that the future of PD diagnoses generally, and BPD specifically, rested on developing a dimensional approach to diagnosis (Benjamin, 1993; Clark, 1993; Cloninger, Svrakic, Bayon, & Przybeck, 1999; Livesley, 1998; Miller, Morse, Nolf, Stepp, &

Pilkonis, 2012; Widiger & Costa, 1994). Some of the most salient elements of the process of developing this dimensional model of BPD for DSM-5 will be discussed and the changes proposed for DSM-5 will be outlined briefly.

The process of developing DSM-5 highlighted the challenges of creating a unified definition of BPD based on the vast research literature that exists, as well as accounting for the various individual opinions in the field. Additionally, untenable ideas that were part of the brainstorming process were made public on the DSM5.org website, and people balked at what seemed to be an overly radical and rash departure from the current model. Ultimately, the final decision for DSM-5 was to include two forms of the PD section. The first model, presented in Section II of DSM-5, is the model of PDs delineated in DSM-IV (diagnostic criteria and codes). In Section III of DSM-5 there is an alternative model of PDs, meant to address the shortcomings of DSM-IV, and designed for further research. The intention is that the constructs developed in Section III will become features of Section II in future editions of the DSM, upon further research and validation. Some of the watershed moments in coming to this final decision will be discussed below, as well as an explanation of the alternative model of PDs.

First, though, it is important to recognize that the creation of the DSM has always been a political process. Scientific research necessarily has no end date. In an effort to create a provisional diagnostic system, which has many important practical implications, people create arbitrary deadlines and end dates. No matter when these dates are set for, they inevitably come in the middle of the research process. Thus, each DSM revision hinges on research that has been completed, and cannot include the lines of research that are still in progress. Furthermore, the revision process is often dictated by work groups, which are based on traditional DSM chapter headings, such as mood disorders, anxiety disorders, and personality disorders. Given what we know about psychopathology, and how much biological, clinical, and diagnostic overlap exists between disorders, this method for writing

the DSM does not allow for substantial cross-fertilization or collaboration between the different work groups. Ultimately, the process of writing the DSM ends up eclipsing potentially fruitful and elucidating avenues of research.

DSM-5 was overseen by a task force, comprising primarily psychiatrists, and was co-chaired by David Kupfer, MD, and Darrel Regler, MD. The American Psychiatric Association (APA) Board of Trustees in turn oversaw the task force. The individual members of the task force also served as chairs of the specific work groups. In thinking about changes in PDs generally for DSM-5, some members of the Personality and Personality Disorder (P & PD) Work Group felt committed to maintaining continuity with DSM-IV, despite the drawbacks. Other members, in response to the limitations of the traditional medical-categorical perspective on psychopathology, pushed for changes based on an individual difference perspective, in which PD psychopathology would be understood using quantitative models developed from analysis of observable signs and symptoms. In these models, data would delineate the constructs, thereby allowing them to be more inductive than deductive. That is to say, the constructs of individual PDs would flow from the data itself, as opposed to from preconceived notions of a disorder, based primarily on clinical experience, as this approach has frequently been shown to be flawed (Grove, 2005). This iterative method of diagnosis development differs from past revisions of the DSM, in which the data collection has primarily been dictated by the existing diagnostic categories, circumscribing the realm of possible findings.

Using this novel guiding principle, many different quantitative individual difference models were considered and inspiration was drawn from both basic personality and personality disorder research (Harkness & McNulty, 1994; Livesley, 2003; Widiger, Costa, & McCrae, 2002). Meetings about the future of PDs in DSM-5 began as early as 2004. Researchers in attendance agreed that a dimensional focus was necessary for guiding the thinking about the structure of PDs. There was enthusiasm for developing a new

dimensional approach to better articulate the way personality pathology exists, and as a way of creating continuity between the literatures on basic personality and maladaptive personality. Under the direction of the task force, a hybrid model of PDs was developed, combining the elements of both a dimensional and categorical diagnostic system. Upon completion, in November 2012, the task force endorsed this novel model of PDs, but the board of trustees voted to maintain the DSM-IV PD categories. The final decision was to include the DSM-IV PDs, with the criteria unchanged, in Section II of DSM-5, and to include the alternative model of PDs in Section III of DSM-5 (Krueger, 2013).

In the DSM-5 alternative model, PDs are characterized by impairments in personality functioning and pathological personality traits. Only six out of the current ten PD diagnoses are explicitly included in this model. They are antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PDs. In addition to these specific PDs, a novel feature found in Section III is the diagnosis of PD-Trait Specified (PD-TS), which is given when the general diagnostic criteria for a PD are met, meaning the presence of impairments in personality functioning and pathological personality traits, but none of the six specified PDs is appropriate. We will explain PD-TS below, but the hope is that it will help fill the diagnostic niche of PDNOS, while providing descriptive information about the exact maladaptive traits present. In this way, PD-TS will avoid the pitfalls of the PDNOS diagnosis, such as inadequate coverage and lack of clinical utility, by providing important clinical information and diagnostic coverage of this patient population.

The general criteria for PD in the alternative model require two determinations, which represent the hybridism of the model. The first determination is that there is a level impairment in personality functioning, either within the person's concept of self, or interpersonally. At the same time, in order to meet for a PD in the alternative model, one or more pathological personality traits must be present. The other general criteria for a PD in Section III of DSM-5 include relative stability over time tracing back to

adolescence or early adulthood; relatively pervasive and inflexible across situations; not better explained by another medical condition or substance use; and not better understood as normal for a person's developmental stage or sociocultural environment. All DSM-5 Section III PDs described by criterion sets and PD-TS meet these general criteria, by definition.

In the alternative model of PDs, impairments in personality functioning are defined as disturbances in self- and interpersonal functioning, but they are measured on a continuum. Self-functioning involves identity and self-direction; interpersonal functioning involves empathy and intimacy. In order to measure these, the alternative model provides The Level of Personality Functioning Scale, measuring personality functioning from no impairment to severe impairment (Bender, Morey, & Skodol, 2011). Thus, though there continue to be cutoffs for delineating specific PDs in this model, there still exists a way to indicate subthreshold impairment. All people, regardless of the presence or absence of personality pathology, can be described using the Level of Personality Functioning Scale.

Beyond the assessment of impairment in personality functioning, the alternative model for PDs has a system for assessing and recording pathological personality traits. Pathological personality traits are organized into five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. These domains consistently map onto the highly replicated Five-Factor Model (FFM), and can be viewed as the maladaptive extreme ends of the domains of FFM personality traits (Fruyt et al., 2013; Thomas et al., 2013). These domains have also been further broken down into 25 more specific trait facets, providing space to give more descriptive information about a person's specific personality profile and impairments. Maladaptive traits were identified through an iterative process starting with 37 trait facets which were ultimately narrowed down to 25 trait facets empirically (Krueger et al., 2012; Krueger et al., 2011). These traits represent the maladaptive poles on personality dimensions

with polar opposites. Noting the high scores on the opposite poles can be important as well, as they can serve as protective factors, and may facilitate treatment or positive coping. Again, this system offers a dimensional way of describing all people's personalities, regardless of whether impairment is present or not. This rubric is important because it provides a way of assessing and describing subthreshold personality pathology. Having a way to describe personality traits can also be helpful in treating people with Axis I disorders such as anxiety and mood disorders. Personality plays an important role in all psychopathology and functioning and, thus, having a system for describing personality traits is a huge step forward in the diagnostic system.

In addition to impairment in personality functioning and the presence of pathological personality traits, the model of PDs in Section III of DSM-5 requires that these features are relatively pervasive and relatively stable. They are supposed to be pervasive in a range of contexts, maladaptive, and inflexible, meaning that these patterns lead to disabilities in social, occupational, or other domains. Similarly, the impairments in functioning and traits are supposed to be relatively stable over time. It is important to highlight the word *relatively* which is used in the alternative model of PDs in DSM-5. Despite the research discussed above, which has shown that personality disorders do change and improve over time, the language from DSM-IV does not accommodate for the changes in the disorder over time. As laid out in the PD section developed for DSM-IV, the BPD diagnosis is primarily defined by specific symptom patterns, which have been shown to be mutable over time, as opposed to the more enduring trait and affective features of the disorder (Hopwood & Zanarini, 2010). Thus, the fact that the diagnosis has been defined by its stability does not optimally describe the disorder in nature.

The alternative model for DSM-5 lays out room for change in the diagnosis or symptoms, incorporating research about disorders in time. Even personality traits, which are considered to be relatively stable over time, do change over the course of the life-span (Roberts & DelVecchio,

2000; Roberts, Walton, & Viechtbauer, 2006). Hence the alternative model acknowledges that maladaptive personality patterns can evolve over time. Without this understanding, a discussion of treatments seems futile. Hopefully this linguistic change will augur an increased focus on developing treatments for these challenging disorders more broadly (for example, most contemporary treatment research on PDs focuses primarily on BPD). It is important to also note that DSM-5 did away with the multiaxial system, which had Axis I and Axis II disorders assessed separately. This change in the structure of the DSM serves as an acknowledgment that personality disorders are not different in kind than Axis I disorders, another way of indicating the importance for developing treatments for these disorders (Markon, 2010).

The six PDs specified in DSM-5 are all characterized by the general impairment in personality functioning, but also by specific personality traits that make up the disorder. In order to meet for BPD in the alternative model in DSM-5, a person must exhibit four or more pathological personality traits out of seven. The traits include Emotional Lability (as an aspect of Negative Affectivity), Anxiousness (Negative Affectivity), Separation Insecurity (Negative Affectivity), Depressivity (Negative Affectivity), Impulsivity (Disinhibition), Risk Taking (Disinhibition), and Hostility (Antagonism). Specifically, in order to receive a diagnosis of BPD, a person must endorse at least one of the following: impulsivity, risk taking, or hostility. Thus, a BPD diagnosis hinges on a general assessment of overall personality impairment as well as a confluence of specific maladaptive personality traits.

One could argue that this system seems likely to perpetuate the problems described earlier with polythetic diagnoses seen in DSM-IV. An initial response is that these traits have been shown to have good coverage of DSM-IV BPD (Hopwood, Thomas, Markon, Wright, & Krueger, 2012). As Trull (2005) argues, it is important that a dimensional model of personality pathology is coordinated with DSM-IV PDs in order to ease the transition between a categorical model and a dimensional system. Thus, the specific PD

categories laid out in the alternative model of DSM-5 can be seen as a middle ground between the DSM-IV categorical system and a purely dimensional model of psychopathology. More noteworthy for clinical purposes, though, is that in Section III of DSM-5, if a person meets for a set of maladaptive traits that are not covered in one of the six diagnostic categories, there still remains a way of identifying and describing personality pathology through the PD-TS diagnosis. Using categorical diagnoses, if someone does not meet for the specific symptoms and traits delineated in the ten PD categories, they would not receive a diagnosis, or they would receive the problematic PDNOS diagnosis. In the new model, there is the flexibility to give a general diagnosis of PD-TS while still indicating specific maladaptive traits and levels of personality functioning descriptions.

A clinician diagnosing a patient with PD-TS would indicate which maladaptive personality trait or traits are present, giving an indication of general impairment and specific information about the dysfunctional personality presentation. This is the novelty of the PD-TS diagnosis, as clinicians will have information about all five domains of personality and will be able to capture the scope of a person's personality functioning, not limited to a specific diagnostic label. In order to meet for PD-TS, a person would have to meet for moderate or greater impairment in personality functioning and would also have to meet for one or more pathological personality trait domains (Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism) or specific trait facets within those domains.

In addition to providing an efficacious solution to the problem of PDNOS, this new trait-based system also ameliorates some of the aforementioned diagnostic problems associated with the high rates of comorbidity. A trait-based diagnostic system would make it unnecessary to diagnose an individual with multiple PDs. Instead, people meet for personality impairment and personality domains and facets. Even if persons do meet for one of the six specific PDs, clinicians would still have the classification tools to indicate whether they meet other personality

features. Meaning, even if they do meet for one of the specific PDs, if they present with other maladaptive personality traits, there is a framework through which to record those as well. For example, psychoticism is not included as a specific trait necessary to receive a diagnosis of BPD under this model. Still, if a patient endorses features of psychoticism, such as cognitive or perceptual dysregulation, it would be important for a clinician to have this information and to have a method with which to convey this information to others involved in this patient's case. Using the model in Section III of DSM-5, a patient would not receive a second, separate PD diagnosis. This would mean one would no longer see patients presenting with multiple PDs. While the issue of comorbidity with other disorders previously on Axis I remains, this dimensional model provides one method for solving the diagnostic problem of comorbidity among PDs. As many Axis I disorders could be understood in a more dimensional fashion as well, Section III of DSM-5 provides a window for reconceptualizing psychopathology in a way that would solve certain of the most nagging diagnostic problems.

The trait aspect of the model has been operationalized using the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2011), and levels of personality impairment can be measured using the Level of Personality Functioning Scale. The PID-5 can be administered via self-reports filled out by the patient or in its informant report form (Markon, 2013). The PID-5 is another of the novel features of DSM-5 Section III in that it directly ties an assessment instrument to the DSM and enables clinicians to assess the models of personality variation described in the DSM using an instrument owned and distributed by the APA. Although the PID-5 is copyrighted by the APA, it is also freely available for clinical use and for research, allowing for a more fluid transfer of information between the clinical and research communities, by providing a unifying measure of assessing PDs.

Overall, the changes that will appear in Section III of DSM-5 help address many of the concerns with the DSM-IV PD (which will also

appear in DSM-5) diagnostic criteria, that were described above. Additionally, these changes, if implemented, could have positive impacts on research, diagnosis, and treatment of BPD, which would hopefully influence the quality of care and treatment for adolescents and children experiencing personality pathology. Though the outcome of the decisions made regarding PDs in DSM-5 reflects ambivalence and uncertainty in the field, it also indicates the investment that researchers and clinicians have in better understanding and more correctly describing PDs. Moving forward, hopefully the energy and momentum that were created in the process of conceiving and writing DSM-5 can propel the field to continue putting research time and money into fleshing out a more accurate and useful conception of PDs, to further the field in research and patient care.

The Upside to Change

It is important to acknowledge that many of the features of Section III of DSM-5 as well as other suggestions proposed in this chapter can seem drastic. Much of the opposition to the changes proposed for DSM-5 and for BPD, specifically, has revolved around the structural and institutional challenges inherent in doing a systematic overhaul of the PD section in the DSM. Changes would have reverberations to areas as far reaching as insurance coverage, governmental funding, and the structure of psychiatric hospitals, in addition to having implications for current lines of research and centers of study, all based on DSM-IV categories. Additionally, improving the diagnostic validity also requires discarding elements of diagnosis that have come to feel synonymous with BPD. Fundamental changes such as these can be difficult. Still, it is important to note the ways that changes in the diagnosis could positively impact clinical care.

One of the primary arguments for maintaining categorical diagnostic criteria sets is that they create a unified conception of a disorder, thereby aiding treatment development and helping clinicians to hone in on a specific treatment

plan for a patient with a given diagnosis (Kendell & Jablensky, 2003; Kraemer, Noda, & O'Hara, 2004). Yet for BPD, the diagnostic confusion delineated above manifests in the array of validated treatments available for the disorder, all of which focus on different features of the diagnosis. For example, the most frequently utilized and highly researched treatment for BPD is DBT. DBT was originally developed by Marsha Linehan to treat parasuicidal and borderline women (Linehan 1987a, 1987b) and is now used broadly, including for treating adolescents with borderline features (Rathus & Miller, 2002). DBT rests on Linehan's biosocial theory of BPD, which is essentially a diathesis-stress model of the disorder. At its core, the biosocial theory of BPD argues that these patients have a biological propensity toward emotional vulnerability, or the trait of experiencing frequent and intense emotional reactions, which interacts with an "invalidating environment" and results in dysfunctional behavioral patterns (Linehan, 1993).

Based on this theory, emotional vulnerability, which is reflected in the affective symptoms of the DSM-IV BPD diagnosis, rests at the core of the disorder and the other behaviors and symptoms associated with BPD stem from this basic vulnerability. Hence, DBT operates primarily to teach patients the skills necessary to regulate their emotions while also focusing on improving secondary skills deficits, through modules such as interpersonal effectiveness and distress tolerance (Shearin & Linehan, 1994). Still, despite the fact that this is the most frequent treatment for BPD, given the current polythetic diagnostic system, it would be possible to meet criteria for BPD without primarily endorsing the BPD symptoms that seem most tied to problems with emotion regulation. Though this presentation of the disorder is likely uncommon, in this scenario, one could argue that DBT would not be targeting the core dysfunction and would not be ideal, even for this borderline patient.

Similarly, other treatments for BPD assume different core dysfunctions that reflect different understandings of the essential nature of BPD. For example, MBT, also mentioned above, is another empirically validated therapy for BPD

developed by Bateman and Fonagy (2004). MBT describes the dysfunctions we see in patients with BPD as stemming from their inability to mentalize. By this, they refer to the disorganized attachment experienced by borderline patients in their early relationships and their inability to think about mental states as distinct from the mental states of others, "yet potentially causing actions" (Bateman & Fonagy, 2004, p. 36). This implies that the fundamental dysfunction for people with BPD described by Bateman and Fonagy is both cognitive and interpersonal. They hypothesize that BPD patients have an inability to understand the underlying thoughts that might lie behind the overt behavior of others, particularly in emotionally charged interpersonal situations. This inability causes difficulties in forming intimate relationships and ultimately in self-regulation, leading to maladaptive behaviors, emotion dysregulation, and impulsivity. This guiding theory of BPD places interpersonal relationships at the center of disorder, with emotion dysregulation resulting from cognitive difficulties in relationships. Still, it is possible to meet criteria for BPD without endorsing any symptoms pertaining to interpersonal relationships and, thus, a treatment that focuses on developing a capacity for engaging effectively in interpersonal relationships might not pertain to certain patients with BPD.

These two examples of different treatments for BPD each with a different basic understanding of the mechanisms behind the disorder, underscoring different DSM-IV symptoms, highlight the challenges inherent in the current diagnostic system for treatment development. When a disorder like BPD is based on polythetic, categorical symptoms, it becomes hard to develop a unified conception of the disorder, as presentation can vary substantially between cases. Widely varying clinical presentations mean that treatment development necessarily emphasizes and focuses on specific aspects of the diagnosis, to the exclusion of others.

Furthermore, the validated and effective use of these treatments for other disorders indicates that the treatments likely are not targeting disorder-specific dysfunctions. Rather, it is

possible to understand these treatments as targeting clinical features found in people with BPD, but also people with other psychiatric disorders, explaining their generalizability. For example, DBT targets emotion dysregulation, akin to the lower order personality trait of emotional lability. Though emotional lability is seen in BPD, it can also be found in diverse psychiatric disorders. Thus, it can be argued that DBT effectively targets emotional lability, explaining its effectiveness in treating other disorders, where problems with emotion regulation are also central. As a result, DBT has also been used for treating eating disorders (Linehan & Chen, 2005), suicidality in adolescents and adults (Rathus & Miller, 2002), and depression in older adults (Lynch, Morse, Mendelson, & Robins, 2003), to name just a few examples. MBT operates under the assumption that an inability to mentalize is the key dysfunction among borderlines, but it, too, has been developed for use in other populations, such as for eating disorder patients (Skårderud, 2007). It can be argued that patients with certain other disorders also have difficulty mentalizing, explaining its potential effectiveness for more widespread use.

Not only have these treatments been used successfully for other disorders beyond BPD, indicating that they are targeting some patient characteristics that are not disorder specific, but many of the treatments for BPD discussed above have been shown to be effective for treating BPD, despite operating on different theories of the disorder. Livesley (2012) argues that the various treatments for BPD, most of which focus on a single impairment, do not target the multiple etiologies or the heterogeneity of impairments present in patients with BPD. The practical and theoretical challenges of the diagnosis, therefore, hamper the effectiveness of the various treatments for the disorder. Livesley advocates for an integrated treatment approach, based on an understanding that the disorder is a “pervasive regulation disorder involving emotional, interpersonal, self, cognitive, and behavioral dyscontrol” (Livesley, 2012, p. 58). Given the diversity of symptom presentations in patients with BPD, treatment should begin with general

mechanisms of change identified in all of the treatments and specific interventions should be utilized as different problems come to fore.

Not only have theoretical difficulties in the BPD diagnosis provided challenges for treatment development, but the strict categorical diagnosis has also negatively impacted treatment delivery for children and adolescents displaying BPD symptoms. As it stands, many clinicians are wary about giving out PD diagnoses to children and adolescents. Traditionally, literature about children’s personality development has focused on temperament, which is viewed as biological, evident early in life, and stable throughout development, unlike personality traits. The theory holds that personality continues to change and evolve throughout childhood and adolescence and, thus, it is hard to make statements about a person’s ultimate personality formation. Over time, temperament is believed to give way to more stable personality traits (Frick, 2004). To give a diagnosis to children and adolescents, some believe, denies the normal fluid developmental processes that occur during adolescence (Miller, Muehlenkamp, & Jacobson, 2008).

Research though now shows that personality traits can be identified reliably in childhood, and that certain traits can be measured as early as 3 years old (Halverson et al., 2003). Studies have also shown that childhood personality can link up with research on child psychopathology and with the adult personality-psychopathology literature (Tackett, 2006). Thus, there is evidence that understanding personality pathology in children and adolescents is not out of line with research on basic personality.

Still, as is described above, there is limited stability in PDs in children and adolescents, when they are measured categorically. Therefore, because BPD continues to carry a great deal of stigma (despite efforts to destigmatize the disorder) clinicians remain wary about attaching these labels to children and adolescents, especially if they may prove to be transient. Still, many traits associated with BPD are correlated with high-risk behaviors, and benefit from clinical attention and early intervention. Thus, finding a way to signify the presence

of these traits, without attaching the rigid BPD label, with its various clinical connotations, would be particularly useful for treating adolescents and children with BPD symptoms. More widespread use of the dimensional and trait-based diagnostic system presented in DSM-5 could allow clinicians to provide clinically pertinent information by delineating the relevant maladaptive traits exhibited by children and adolescents. In this way, clinicians could highlight the specific areas of concern for treatment. This would enable patients to get the treatment they need while hopefully lessening the long-term implications of a premature diagnosis of BPD.

Though the fields of personality research and treatment development continue to seem remote from one another in the scientific community, there are already exciting efforts to build bridges between these two fields. For example, researchers have been working on a novel personality-based treatment for adolescents, called *PreVenture*, which is a personality-targeted intervention for adolescent alcohol misuse. This early intervention program has been shown to have promising results for adolescent substance use (Conrod, Castellanos-Ryan, & Strang, 2010). The idea is that by intervening on the level of personality traits, we can more effectively prevent certain negative outcomes. This is one example of ways that a more personality-focused model of psychopathology could positively impact treatment. It also provides a model for pan-diagnostic treatments, which intervene on the personality level and thus can apply to an array of disorders.

The above is just one example of an exciting synthesis of research on basic personality, abnormal personality, and treatment. Ultimately, the DSM-5 process brought together people from a wide variety of research areas throughout the psychology and psychiatry communities and opened many conversations and opportunities for collaboration between researchers in diverse research areas. Despite frustration by many with the process and the outcome, it opened a discussion about a research and clinical area that is clearly of great importance for many. Instead of

closing the discussion with the arbitrary end point of the publication of DSM-5, it is important that these cross-cutting conversations continue, and these research communities continue working together to best describe, classify, and treat psychopathology. Our hope is that moving beyond DSM-5, we will continue to see exciting collaborations between these various research areas, and ongoing discussions about classification, treatment, and research about BPD, PDs, and personality and psychopathology, particularly as they impact the youngest sufferers.

References

- Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, 18, 36–51.
- Bender, D. S., Morey, L. C., & Skodol, A. E. (2011). Toward a model for assessing level of personality functioning in DSM-5, part I: A review of theory and methods. *Journal of Personality Assessment*, 93, 332–346.
- Benjamin, L. S. (1993). *Interpersonal diagnosis and treatment of personality disorders*. New York: Guilford Press.
- Bernstein, D. P., Cohen, P., Velez, C. N., Schwab-Stone, M., Siever, L. J., & Shinsato, L. (1993). Prevalence and stability of DSM-III-R personality disorders in a community based survey of adolescents. *American Journal of Psychiatry*, 150, 1237–1243.
- Bornoalova, M. A., Hicks, B. M., Iacono, W. G., & McGue, M. (2009). Stability, change, and heritability of borderline personality disorder traits from adolescence to adulthood: A longitudinal twin study. *Development and Psychopathology*, 21, 1335–1353.
- Chanen, A. M., Jackson, H. J., McGorry, P. D., Allot, K. A., Clarkson, V., & Hok, P. Y. (2004). Two-year stability of personality disorder in older adolescent outpatients. *Journal of Personality Disorders*, 18, 526–541.
- Chanen, A. M., McCutcheon, L. K., Jovev, M., Jackson, H. J., & McGorry, P. D. (2007). Prevention and early intervention for borderline personality disorder. *Medical Journal of Australia*, 187, S18–S21.
- Clark, L. A. (1993). *Schedule for Nonadaptive and Adaptive Personality (SNAP)*. Minneapolis, MN: University of Minnesota Press.
- Clark, L. A. (2005). Stability and change in personality pathology: Revelations of three longitudinal studies. *Journal of Personality Disorders*, 19, 524–532.
- Clark, L. A., Livesley, W. J., & Morey, L. C. (1997). Special feature: Personality disorder assessment: The

- challenge of construct validity. *Journal of Personality Disorders*, 11, 205–231.
- Clark, L. A., Watson, D., & Reynolds, S. (1995). Diagnosis and classification of psychopathology: Challenges to the current system and future directions. *Annual Review of Psychology*, 46, 121–153.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. (1999). *Psychotherapy for borderline personality disorder*. New York: Wiley.
- Cloninger, C. R., Svrakic, D. M., Bayon, C., & Przybeck, T. R. (1999). Measurement in psychopathology as variants of personality. In C. R. Cloninger (Ed.), *Personality and psychopathology* (pp. 33–65). Washington, DC: American Psychiatric Press.
- Coccaro, E. F., Nayyer, H., & McCloskey, M. S. (2012). Personality disorder—Not otherwise specified: Evidence of validity and consideration for DSM-5. *Comprehensive Psychiatry*, 53, 907–914.
- Conrod, P. J., Castellanos-Ryan, N., & Strang, J. (2010). Brief, personality-targeted coping skills interventions and survival as a non-drug user over a 2-year period during adolescence. *Archives of General Psychiatry*, 67, 85–93.
- Cooper, L. D., Balsis, S., & Zimmerman, M. (2010). Challenges associated with a polythetic diagnostic system: Criteria combinations in the personality disorders. *Journal of Abnormal Psychology*, 119, 886–895.
- Frick, P. J. (2004). Integrating research on temperament and childhood psychopathology: Its pitfalls and promise. *Journal of Clinical Child and Adolescent Psychology*, 33, 2–7.
- Fruyt, F. D., Clercq, B. D., Bolle, M. D., Wille, B., Markon, K. E., & Krueger, R. F. (2013). General and maladaptive traits in Five-Factor framework for DSM-5 in a university student sample. *Assessment*, 20, 295–307.
- Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., et al. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 69, 533–545.
- Grove, W. M. (2005). Clinical versus statistical prediction: The contribution of Paul E. Meehl. *Journal of Clinical Psychology*, 61, 1233–1243.
- Gunderson, J. G., & Pollack, W. (1985). Conceptual risks of the Axis I-II distinction. In H. Klar & L. J. Siever (Eds.), *Biologic response styles: Clinical implications* (pp. 81–95). Washington, DC: American Psychiatric Press.
- Halverson, C. F., Havill, V. L., Deal, J., Baker, S. R., Victor, J. B., & Pavlopoulos, V. (2003). Personality structure as derived from parental ratings of free descriptions of children: The inventory of child individual differences. *Journal of Personality*, 71, 995–1026.
- Harkness, A. R., & McNulty, J. L. (1994). The Personality Psychopathology Five (PSY-5): Issues from the pages of a diagnostic manual instead of a dictionary. In S. Strack & M. Lorr (Eds.), *Differentiating normal and abnormal personality* (pp. 291–315). New York: Springer.
- Hopwood, C. J., Thomas, K. M., Markon, K. E., Wright, A. G. C., & Krueger, R. F. (2012). DSM-5 personality traits and DSM-IV personality disorders. *Journal of Abnormal Psychology*, 121, 424–432.
- Hopwood, C. J., & Zanarini, M. C. (2010). Borderline personality traits and disorder: Predicting prospective patient functioning. *Journal of Consulting and Clinical Psychology*, 78, 585–589.
- Johnson, J. G., Cohen, P., Kasen, S., Skodol, A. E., Hamagami, F., & Brooks, J. S. (2000). Age-related change in personality disorder trait levels between early adolescence and adulthood: A community-based longitudinal investigation. *Acta Psychiatrica Scandinavica*, 102, 265–275.
- Kaess, M., von Ceumern-Lindenstjerna, I. A., Parzer, P., Chanen, A. M., Mundt, C., Resch, F., et al. (2013). Axis I and II comorbidity and psychosocial functioning in female adolescents with borderline personality disorder. *Psychopathology*, 46, 55–62.
- Kamphuis, J. H., & Noordhof, A. (2009). On categorical diagnoses in DSM-5: Cutting dimensions at useful points? *Psychological Assessment*, 21, 294–301.
- Kendell, R. E., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry*, 160, 4–12.
- Kraemer, H. C., Noda, A., & O'Hara, R. (2004). Categorical versus dimensional approaches to diagnosis: Methodological challenges. *Journal of Psychiatric Research*, 38, 17–25.
- Krueger, R. F. (2005). Continuity of Axes I and II: Toward a unified model of personality, personality disorders, and clinical disorders. *Journal of Personality Disorders*, 19, 233–261.
- Krueger, R. F. (2013). Personality disorders are the vanguard of the post-DSM-5.0 era. *Personality Disorders: Theory, Treatment, and Research*, 4, 355–362.
- Krueger, R. F., Deringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine*, 42, 1879–1890.
- Krueger, R. F., & Eaton, N. R. (2010). Personality traits and the classification of mental disorders: Toward a more complete integration in DSM-V and an empirical model of psychopathology. *Personality Disorders: Theory, Research, and Treatment*, 1, 97–118.
- Krueger, R. F., Eaton, N. R., Clark, L. A., Watson, D., Markon, K. E., Derringer, J., et al. (2011). Deriving an empirical structure of personality pathology for DSM-5. *Journal of Personality Disorders*, 25, 170–191.
- Krueger, R. F., & Markon, K. E. (2006). Reinterpreting comorbidity: A model-based approach to

- understanding and classifying psychopathology. *Annual Review of Clinical Psychology*, 2, 111–133.
- Krueger, R. F., Markon, K. E., Patrick, C. J., & Iacono, W. G. (2005). Externalizing psychopathology in adulthood: A dimensional-spectrum conceptualization and its implications for DSM-V. *Journal of Abnormal Psychology*, 114, 537–550.
- Linehan, M. M. (1987a). Dialectical behavior therapy: A cognitive behavioral approach to parasuicide. *Journal of Personality Disorders*, 1, 328–333.
- Linehan, M. M. (1987b). Dialectical behavior therapy for borderline personality disorder: Theory and method. *Bulletin of the Menninger Clinic*, 51, 261–276.
- Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M., & Chen, E. Y. (2005). Dialectical behavioral therapy for eating disorders. In A. Freeman, S. H. Felgoise, A. M. Nezu, C. M. Nezu, & M. A. Reinecke (Eds.), *Encyclopedia of cognitive behavior therapy* (pp. 168–171). New York: Springer.
- Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., Heagerty, P., et al. (2002). Dialectical behavior therapy versus comprehensive validation plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence*, 67, 13–26.
- Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, C. J., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions*, 8, 279–292.
- Livesley, W. J. (1998). Suggestions for a framework for an empirically based classification of personality disorder. *Canadian Journal of Psychiatry*, 43, 137–147.
- Livesley, W. J. (2003). Diagnostic dilemmas in classifying personality disorders. In K. A. Phillips, M. B. First, & H. A. Pincus (Eds.), *Advancing DSM: Dilemmas in psychiatric diagnosis* (pp. 153–189). Arlington, VA: American Psychiatric Association.
- Livesley, W. J. (2012). Moving beyond specialized therapies for borderline personality disorder: The importance of integrated domain-focused treatment. *Psychodynamic Psychiatry*, 40, 47–74.
- Lynch, T. R., Morse, J. Q., Mendelson, T., & Robins, C. J. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *The American Journal of Geriatric Psychiatry*, 11, 33–45.
- Markon, K. E. (2010). Modeling psychopathology structure: A symptom-level analysis of Axis I and II disorders. *Psychological Medicine*, 40, 273–288.
- Markon, K. E., Krueger, R. F., & Watson, D. (2005). Delineating the structure of normal and abnormal personality: An integrative hierarchical approach. *Journal of Personality and Social Psychology*, 88, 139–157.
- Markon, K. E., Quilty, L. C., Bagby, R. M., & Krueger, R. F. (2013). The development and psychometric properties of an informant-report form of the personality inventory for DSM-5 (PID-5). *Assessment*, 20, 370–383.
- Meijer, M., Goedhart, A. W., & Treffers, P. D. A. (1998). The persistence of borderline personality disorder in adolescence. *Journal of Personality Disorders*, 12, 13–22.
- Miller, J. D., Morse, J. Q., Nolf, K., Stepp, S. D., & Pilkonis, P. A. (2012). Can DSM-IV borderline personality disorder be diagnosed via dimensional personality traits? Implications for DSM-5 personality disorder proposal. *Journal of Abnormal Psychology*, 121, 944–950.
- Miller, A. L., Muehlenkamp, J. J., & Jacobson, C. M. (2008). Fact or fiction: Diagnosing borderline personality disorder in adolescents. *Clinical Psychology Review*, 28, 969–981.
- Mineka, S., Watson, D., & Clark, L. A. (1998). Comorbidity of anxiety and unipolar mood disorders. *Annual Review of Psychology*, 49, 377–412.
- Morey, L. C., & Zanarini, M. C. (2000). Borderline personality: Traits and disorder. *Journal of Abnormal Psychology*, 109, 733–737.
- Oldham, J. M. (2005). Personality disorders. *Focus*, 3, 372–382.
- Pfohl, B., Coryell, W., Zimmerman, M., & Stangl, D. (1986). DSM-III personality disorders: Diagnostic overlap and internal consistency of individual DSM-III criteria. *Comprehensive Psychiatry*, 27, 21–34.
- Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide & Life Threatening Behavior*, 32, 146–157.
- Roberts, B. W., & DelVecchio, W. F. (2000). The rank-order consistency of personality traits from childhood to old age: A quantitative review of longitudinal studies. *Psychological Bulletin*, 126, 3–25.
- Roberts, B. W., Walton, K. E., & Viechtbauer, W. (2006). Patterns of mean-level change in personality traits across the life course: A meta-analysis of longitudinal studies. *Psychological Bulletin*, 132, 1–25.
- Shearin, E. N., & Linehan, M. M. (1994). Dialectical behavior therapy for borderline personality disorder: Theoretical and empirical foundations. *Acta Psychiatrica Scandinavica*, 89, 61–68.
- Silverman, M. H., Frankenburg, F. R., Reich, D. B., Fitzmaurice, G., & Zanarini, M. C. (2012). The course of anxiety disorders other than PTSD in patients with borderline personality disorder and Axis II comparison subjects: A 10-year follow-up study. *Journal of Personality Disorders*, 26, 804–814.
- Skårderud, F. (2007). Eating one's words: Part III. Mentalisation-based psychotherapy for anorexia nervosa—An outline for a treatment and training manual. *European Eating Disorders Review*, 15, 323–339.
- Skodol, A. E., Clark, L. A., Bender, D. S., Krueger, R. F., Morey, L. C., Verheul, R., et al. (2011). Proposed changes in personality and personality disorder assessment and diagnosis for DSM-5 Part I: Description and rationale. *Personality Disorders: Theory, Research, and Treatment*, 2, 4–22.
- Tackett, J. L. (2006). Evaluating models of the personality-psychopathology relationship in children and adolescents. *Clinical Psychology Review*, 26, 584–599.
- Thomas, K. M., Yalch, M. M., Krueger, R. F., Wright, A. G. C., Markon, K. E., & Hopwood, C. J. (2013). The

- convergent structure of DSM-5 personality traits and five-factor model trait domains. *Assessment*, 20, 308–311.
- Trull, T. J. (2005). Dimensional models of personality disorder: Coverage and cutoffs. *Journal of Personality Disorders*, 19, 262–282.
- Verheul, R., Bartak, A., & Widiger, T. A. (2007). Prevalence and construct validity of personality disorder not otherwise specified (PDNOS). *Journal of Personality Disorders*, 21, 359–370.
- Verheul, R., & Widiger, T. A. (2004). A meta-analysis of the prevalence and usage of the personality disorder not otherwise specified (PDNOS) diagnosis. *Journal of Personality Disorders*, 18, 309–319.
- Westen, D., & Shedler, J. (2000). A prototype matching approach to diagnosis personality disorders: Toward DSM-V. *Journal of Personality Disorders*, 14, 109–126.
- Westen, D., Shedler, J., Durrett, C., Glass, S., & Martens, A. (2003). Personality diagnoses in adolescence: DSM-IV axis II diagnoses and an empirically derived alternative. *American Journal of Psychiatry*, 160, 952–966.
- Widiger, T. A., & Costa, P. T. (1994). Personality and personality disorders. *Journal of Abnormal Psychology*, 103, 78–91.
- Widiger, T. A., Costa, P. T., & McCrae, R. R. (2002). A proposal for Axis II: Diagnosing personality disorders using the five factor model. In P. T. Costa & T. A. Widiger (Eds.), *Personality disorders and the five factor model of personality* (2nd ed., pp. 431–456). Washington, DC: American Psychological Association.
- Widiger, T. A., Frances, A., Spitzer, R. L., & Williams, J. B. (1988). The DSM-III-R personality disorders: An overview. *American Journal of Psychiatry*, 145, 786–795.
- Widiger, T. A., Livesley, J. W., & Clark, L. A. (2009). An integrative dimensional classification of personality disorder. *Psychological Assessment*, 21, 243–255.
- Widiger, T. A., & Shea, T. (1991). Differentiation of Axis I and Axis II disorders. *Journal of Abnormal Psychology*, 100, 399–406.
- Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. *American Psychologist*, 62, 71–83.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy*. New York: Guilford Press.
- Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Tricka, A., Levin, A., et al. (1998a). Axis I comorbidity of borderline personality disorder. *American Journal of Psychiatry*, 155, 1733–1739.
- Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Tricka, A., Levin, A., et al. (1998b). Axis II comorbidity of borderline personality disorder. *Comprehensive Psychiatry*, 39, 296–302.
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and Axis II comparison subjects: A 16 year prospective follow-up study. *American Journal of Psychiatry*, 169, 476–483.

Suggested Reading

- Krueger, R. F., Deringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine*, 42, 1879–1890. (This article introduces the PID-5, or the Personality Inventory for DSM-5, which provides an assessment tool for the personality traits described in Section III of DSM-5. This instrument is copyrighted by the APA (American Psychiatric Association) but it is freely available for use in clinical and research settings by downloading it from: <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Personality>.)
- Livesley, W. J. (2012). Moving beyond specialized therapies for borderline personality disorder: The importance of integrated domain-focused treatment. *Psychodynamic Psychiatry*, 40, 47–74. (This article offers an argument for a more integrated and less specialized approach for treating BPD patients. Given well-established problems with DSM-IV and DSM-5 Section II personality disorder diagnoses and the changes suggested in Section III of DSM-5, this model for a more fluid attitude toward treating BPD patients provides a useful lens for thinking about treatment in light of suggested changes.)
- Markon, K. E., Krueger, R. F., & Watson, D. (2005). Delineating the structure of normal and abnormal personality: An integrative hierarchical approach. *Journal of Personality and Social Psychology*, 88, 139–157. (This article provides a useful model for understanding the integration of normal and abnormal personality. The model of personality pathology presented in Section III of DSM-5 moves towards this integration, which is important for better synthesizing the currently disparate literatures of personality pathology and normal personality.)
- Tackett, J. L. (2006). Evaluating models of the personality-psychopathology relationship in children and adolescents. *Clinical Psychology Review*, 26, 584–599. (In this article, Tackett explains how the personality and personality disorder literature pertain to adolescents and children, who are often left out of these models.)
- Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. *American Psychologist*, 62, 71–83. (This is a concise discussion of the most pressing intellectual and clinical problems found in the personality disorder model from DSM-IV, which has been carried to Section II of DSM-5.)